No. 15-274

IN THE

# Supreme Court of the United States

WHOLE WOMAN'S HEALTH; AUSTIN WOMEN'S HEALTH CENTER; KILLEEN WOMEN'S HEALTH CENTER; NOVA HEALTH SYSTEMS D/B/A REPRODUCTIVE SERVICES; SHERWOOD C. LYNN, JR., M.D.; PAMELA J. RICHTER, D.O.; AND LENDOL L. DAVIS, M.D., *ON BEHALF OF THEMSELVES AND THEIR PATIENTS*,

*Petitioners*,

*v.*

KIRK COLE, M.D., COMMISSIONER OF THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES; MARI ROBINSON, EXECUTIVE DIRECTOR OF THE TEXAS MEDICAL BOARD, IN THEIR OFFICIAL CAPACITIES,

*Respondents*.

**On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit**

## BRIEF OF *AMICI CURIAE* SOCIETY OF HOSPITAL MEDICINE AND SOCIETY OF OB/GYN HOSPITALISTS IN SUPPORT OF PETITIONERS

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## STATEMENT OF INTEREST OF THE *AMICI CURIAE*[1]

The Society of Hospital Medicine (the "Society," formerly the National Association of Inpatient Physicians) is a non-profit professional medical society founded in 1998. The Society's mission is to promote exceptional care for hospitalized patients by: promoting high-quality and high-value health care for every hospitalized patient; advancing the state of the art in hospital medicine through education and research; improving hospitals and the health care community through innovation, collaboration, and patient-centered care; and supporting and nurturing a vibrant, diverse, and multidisciplinary membership to ensure the long-term health of hospital medicine. The Society has more than 13,000 members who are practicing hospitalists in the United States.

Hospitalists are physicians who specialize in the practice of hospital medicine and may undergo post-residency training specifically focused on hospital medicine, or acquire other indicators of expertise in the field. Hospital medicine is a medical specialty

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[1] Pursuant to Supreme Court Rule 37.2, the Society, through counsel, has timely notified the parties of its intent to file an *amicus curiae* brief. The parties have consented. Pursuant to Rule 37.6, undersigned counsel certify that: (1) no counsel for a party authored this brief in whole or in part; (2) no party or party's counsel contributed money that was intended to fund the preparation or submission of this brief; and (3) no person or entity- other than *amici curiae*, its members, and its counsel – contributed money intended to fund the preparation or submission of this brief.

dedicated to the delivery of comprehensive medical care to hospitalized patients through both clinical expertise and fluency in the complexities of delivering care in the hospital setting.

The Society supports evidenced-based health care laws and policies that improve quality, safety, and efficiency, and recognize the pivotal role that hospitalists play in improving healthcare value for hospitalized patients.

The Society of Ob/Gyn Hospitalists ("SOGH") is a non-profit professional medical society founded in 2011. Ob/Gyn hospitalists are physicians who specialize in the practice of hospital medicine specific to Obstetrics and Gynecology. Ob/Gyn hospitalists are dedicated to the delivery of high quality care to hospitalized obstetrical and gynecological patients through both clinical expertise and fluency in the complexities of delivering care in the hospital setting.

SOGH is a rapidly growing group of physicians, midwives, nurses, and other individuals in the field. It is the only physician organization in the U.S. solely committed to educating and to advancing the goals of Ob/Gyn hospitalists. SOGH seeks to enhance the safety and quality of Ob/Gyn Hospital Medicine by promoting excellence through education, coordination of hospital teams, and collaboration with healthcare delivery systems.

Both the Society and SOGH oppose laws and policies that impose limitations or requirements on the delivery of health care without any scientific foundation and that do not improve patient care.

## INTRODUCTION

House Bill 2 ("H.B. 2"), enacted in 2013, mandates that all abortion providers obtain admitting privileges at hospitals within thirty (30) miles of the location where the abortion is performed. H.B. 2 also requires that most abortion providers satisfy the same requirements as ambulatory surgical centers. The Texas legislature purported to justify these requirements as a means of protecting patient health and safety. This brief focuses solely on the admitting privileges component of H.B. 2, which is the matter on which the Society has particularized information that may be helpful to the Court. This brief will demonstrate that the admitting privileges requirement of H.B. 2 has no reasonable medical basis.

In today's modern practice of medicine, in Texas and across the country, hospitalists—physicians that specialize in hospital medicine—play the role of admitting and attending physicians, thereby ensuring the quality and continuity of medical care for inpatient hospital treatment. They provide the primary treatment in the hospital setting, treating patients and working successfully in partnership with outpatient physicians that lack admitting privileges.

Admitting privileges are appropriate for physicians who regularly admit patients. But requiring physicians who specialize in outpatient procedures with low incidence of post-procedure complications, whether that specialty is podiatry or gynecology, to maintain privileges serves no medical purpose, is inconsistent with modern medicine, and is unnecessary to ensure continuity of care. Having

a hospitalist serve as the admitting or attending physician does not deprive patients of quality inpatient or outpatient services.

First, the willingness of a hospital to admit, and the ability of a hospital to care for, a patient in need of hospitalization in the unlikely event that an abortion gives rise to the need for hospitalization is not impacted by whether the abortion provider has admitting privileges.

Second, though hospitals may, in varying degrees, consider medical competence in deciding whether to grant admitting privileges or allow them to be maintained, hospitals may also consider a range of other factors, many economic, in deciding whether to grant admitting privileges. A particular hospital's decision to grant or not grant an outpatient provider admitting privileges cannot be regarded as a medical decision concerning provider competence or one that bears upon the quality of care expected from that provider. It is inappropriate to conclude that a given provider is capable or not based on a hospital credentialing committee's decision to grant the provider privileges.

Third, the admitting privileges requirement will not enhance the quality of care for women who seek, or have obtained, an abortion. Hospitals and hospitalists today are geared to providing comprehensive treatment to admitted patients. They do so thanks to the dedicated role of the hospitalist in coordinating care, collaborating with outpatient physicians, and shepherding the patient through the intricacies of hospitalization.

Requiring an outpatient provider to have "admitting privileges" is unlikely to impact the

ability of the hospital to provide high quality treatment. Indeed, particularly for an outpatient procedure with low incidence of post-procedure complications, such as abortion, where the abortion provider (like many other surgeons providing outpatient surgery) is unlikely to have had any extended historic connection to the patient, the idea of requiring the provider to have admitting privileges, is particularly anomalous. There is no reason to expect that the possession of admitting privileges would in any way contribute to more successful outcomes for the patient.

The Texas legislature purported to justify its admitting privileges requirements as a means of protecting patient health and safety. But the admitting privileges requirement of H.B. 2 has no reasonable medical basis. Moreover, H.B. 2's admitting privileges requirement will subject the ability of women seeking an abortion to the non-medical decisions of hospitals which may or may not choose to grant a particular provider admitting privileges for reasons having little or no relationship to the health of patients. As such, H.B. 2's admitting privileges requirement lacks a rational relationship to the goal of protecting a woman's health.

## ARGUMENT

The ostensible purpose underlying H.B. 2's admitting privilege's requirement is the desire to "raise the standard and quality of care for women seeking abortions and to protect the health and welfare of women seeking abortions."[2] But requiring

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[2] Pet. App. 25a; Resp. C.A. Br. 13.

physicians who specialize in outpatient procedures with low incidence of post-procedure complications, such as abortion, to maintain admitting privileges is both unnecessary and inconsistent with the modern practice of medicine. Texas H.B. 2's admitting privileges requirement thus lacks any medical basis.

## I. Hospitalists Are Specialists in the Practice of Medicine in the Hospital Setting

Hospital medicine is a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients. Hospital medicine has been a significant part of the US health care landscape for more than two decades. In American medicine, inpatient care is increasingly provided by hospitalists—doctors specializing in treating patients in the hospital—rather than by physicians with outpatient practices venturing into the hospital to treat their hospitalized patients. There are now more than 44,000 hospitalists caring for inpatients at hospitals across the country, performing an array of essential services, including:

- Coordinating medical care
- Admitting patients
- Serving as attending physicians for inpatients
- Overseeing the transition from inpatient to outpatient
- Co-managing patients with surgeons, internal medicine specialists, and other clinicians.[3]

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[3] Society of Hospital Medicine, *Definition of a Hospitalist and Hospital Medicine*, Nov. 4, 2009,

(continued...)

Simply put, hospitalists are physicians who have restricted the scope of their practice to the hospital setting. They have a special set of skills and they are responsible for improving care in the hospital setting.[4] In fact, the Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") specifically recognizes that hospitalists play an important role in hospital inpatient admissions and the certification of medical necessity as a condition of payment under Medicare.[5] For these reasons, hospital medicine is the fastest growing specialty in American medicine.[6]

One example of how hospitalists are utilized in today's hospitals is patient admissions from the emergency room. Today, most doctors who staff hospital emergency rooms do not have hospital

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http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx?hkey=fb083d78-95b8-4539-9c5b-58d4424877aa; *see also* Mark Williams, *Hospital Medicine's Evolution—The Next Step*, 1 Journal of Hospital Medicine 1, 1-2 (Jan/Feb 2006); *The Expanding Role of Hospital Medicine and the Co-Management of Patients*, The Quarterly Journal for Health Care Practice and Risk Management, Vol. 21 Spring 2013 at 6.

[4] Christine K. Cassel, *Hospital Medicine: An Important Player in Comprehensive Care*, 1 Journal of Hospital Medicine 3, 3-4 (Jan./Feb. 2006).

[5] Center for Medicare, U.S. Dep't Health & Human Svcs., *Hospital Inpatient Admission Order and Certification*, (Jan. 30, 2014) at 3 ("The admitting physician of record may be [...] a hospitalist.").

[6] *The Expanding Role of Hospital Medicine and the Co-Management of Patients*, The Quarterly Journal for Health Care Practice and Risk Management, Vol. 21 Spring 2013 at 3.

admitting privileges. Rather, the standard practice is that if a patient comes into the emergency room, and an emergency room doctor determines that it is medically necessary for the patient to be admitted as a hospital inpatient, the emergency room doctor will contact hospitalists to coordinate care for that patient and request that the hospitalists admit the patient to the hospital.[7]

## II. Requiring Physicians Who Specialize in Outpatient Procedures with Low Incidence of Post-Procedure Complications, Such As Abortion, to Have Admitting Privileges is Inconsistent with The Modern Practice of Hospital Medicine.

Texas has asserted that H.B. 2's admitting privileges requirement protects women's health.[8] This assertion is not supported by any clinical rationale. H.B. 2 ignores current best practices in hospital medicine. It does not advance any interest in continuity of care or provide any other medical benefit.

A hospital's decision to permit a physician to admit patients to a hospital, perform services in the hospital setting, and obtain appointment to the

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[7] Deborah Gesensway, *Admissions From the ED: Are Patients Leaving Too Fast or Too Slow*, Today's Hospitalist (Feb. 2011), http://www.todayshospitalist.com/index.php?b=articles_read&cnt=1166.

[8] *See* Defendants' Trial Brief at 42, *Planned Parenthood of Greater Tex. Surg. Health Servs. v. Abbott*, 951 F. Supp. 2d 891 (W.D. Tex. 2013) ("HB2 was enacted to protect the health and safety of patients.").

hospital's medical staff may be referred to broadly as "credentialing."[9] Hospitals may offer a physician admitting privileges, which enable the physician to admit patients into the hospital for inpatient treatment within the scope of the physician's clinical expertise.[10] Admitting privileges are specific in nature; that is, a physician applies for privileges based on particular clinical services and expertise.[11] Admitting privileges are unnecessary for the provision of care in an outpatient setting, including the emergency room, where patients may receive treatment without admission to the hospital.[12]

As discussed, *infra*, hospitals often condition admitting privileges on reaching a certain number of admissions per year, but the very nature of certain outpatient procedures makes it virtually impossible for providers of outpatient procedures with low incidence of post-procedure complications to satisfy

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[9] Wendy Crimp, Sally J. Pelletier, Vicki L. Searcy, and Mark Smith, *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-based Privileges 4th Ed.* 3-4 (2007) ("This process of collecting, reviewing, and assessing practitioners' qualifications for membership/clinical privileges is commonly referred to as *credentialing*.").

[10] Wendy Crimp, Sally J. Pelletier, Vicki L. Searcy, and Mark Smith, *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-based Privileges 4th Ed.* 12, 23-24, 73 (2007) (explaining that a hospital cannot assume a given physician can perform every task associated with a particular category of practitioner and citing the use of criteria-based credentialing and the focused professional practice evaluation in credentialing determinations).

[11] *Id.*

[12] *See supra* at n.7.

those requirements.[13] Indeed, hospitals have little reason to grant privileges to a physician specializing in an outpatient procedure with an extremely low complication rate whose patients seldom need inpatient hospital care. Abortion is a low-risk outpatient procedure.[14] Requiring physicians who

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[13] Mark A. Smith and Sally Pelletier, *Assessing the Competency of Low-Volume Practitioners: Tools and Strategies for OPPE and FPPE Compliance*, 2d Ed. 79 (2009) (Recommending that low-volume physicians who are not clinically active at hospitals or hospital-owned ambulatory clinics not be given admitting privileges because "[t]hese practitioners put a strain on your organization's credentialing resources, use a great deal of the [medical staff services department]'s energy and time, and take up space on the credentialing committee's or [medical executive committee]'s agenda that should be devoted to more [economically] worthwhile activities.").

[14] See *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014) ("The great weight of the evidence demonstrates that, before the act's passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure. . . . Abortion, as regulated by the State before the enactment of House Bill 2, has been shown to be much safer, in terms of minor and serious complications, than many common medical procedures not subject to such intense regulation and scrutiny").

Complications from abortions are exceedingly rare and seldom acute. For the most common type of surgical abortion, complications occur in no more than 1 out of 112 physician-performed first-trimester procedures and 94% of those complications are "minor." Tracy A. Weitz *et al.*, *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Public Health 454, 457–58 (2013), and Kelly Cleland et al., *Significant Adverse Events and*

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specialize in low-risk outpatient procedures, such as abortion, to maintain privileges is inconsistent with modern medicine and will deprive patients of quality outpatient services because it will limit the number of physicians who can provide those outpatient services.[15]

In modern American medicine, inpatient care is provided by hospitalists—doctors specializing in treating patients in the hospital—rather than by physicians treating patients of their outpatient practices when hospitalized. Even if an outpatient physician has admitting privileges, that physician may not ultimately care for a patient that she has admitted to a hospital. Rather, the outpatient physician may admit the patient but elect to defer inpatient care to a hospitalist.

Regardless whether an outpatient physician has admitting privileges, practice privileges, or no privileges, hospitalists ensure efficient and high-quality care for the physician's patient. Hospitalists work in partnership with outpatient physicians—even those who do not admit patients—to provide quality patient care.

The hospitalist model creates significant benefits for patients and hospitals, such as improved

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*Outcomes After Medical Abortion*, 121 *Obstetrics & Gynecology* 166, 169 (2013).

[15] *See, e.g.*, Deborah Haas-Wilson, *Managed Care and Monopoly Power: The Antitrust Challenge* at 133 (2003) ("If qualified potential entrants are denied admitting privileges at the only local hospital or the superior local hospital, then entry into the market for physician services is less likely to occur.").

health outcomes, shorter hospital stays, and financial savings through more efficient treatment.[16] Because the modern hospital is extremely complicated, there are many benefits to having dedicated experts in hospital medicine provide treatment rather than relying on physicians with outpatient practices who may spend very little time within a hospital.[17] Hospitalists help to ensure coordination among medical providers and effective communication with patients.

The hospitalist model also facilitates continuity of care. Hospitalists coordinate patient care upon admission, during the hospitalization, and when a patient is discharged. Continuity of care is achieved through communication between physicians with differing specialties, rather than through the older practice of having a generalist provide both inpatient and outpatient care. Hospitalists are in the hospital at all times and are therefore better able to monitor patients than a physician with responsibilities to patients outside the hospital. This structure improves the patient experience and continuity of care.

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[16] Kimberly Morrison, *Hospitalists Increase Efficiency, Patient Satisfaction*, Jacksonville Business Journal, Sept. 4-10, 2009, http://www.ipchealthcare.com/assets/004/7114.pdf (citing shorter lengths of stay, improved efficiency, and higher quality care under the hospitalist model).

[17] *Cf.* Steven R. Eastaugh, *Health Care Finance and Economics* 78 (2004) (explaining that hospitals may withhold admitting privileges from inefficient physicians to prevent erosion of financial standing and resources by "imprudent, wasteful use of hospital resources to admit patients").

Hospitalists promptly ascertain the pertinent medical history and information after patient admission, and provide high-quality care in the hospital setting regardless of the type of procedure necessitating hospitalization, particularly when a patient is admitted from the emergency department. When a patient presents at a hospital emergency department Hospitalists work with the emergency department to conduct a patient assessment and admit the patient to general medicine or other hospital departments as necessary.[18] Doing so reduces emergency department overcrowding, provides timely care, and improves qualify of care. [19]

Upon hospitalization of a patient, a hospitalist may establish a communication protocol with the patient's outpatient primary care provider or other provider, such as an ob-gyn, as appropriate, which ensures secure, timely, and reliable transfer of information. [20] This protocol generally addresses the

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[18] Eric Howell, *Hospitalists Hold Key to Admissions Door for ED Patients*, The Hospitalist (Aug. 1, 2013) ("Hospitalists are critical partners in quality improvement, including ED flow, and can positively impact our patients, our institutions, and our specialty.").

[19] *Id.*; *see also* Smitha R. Chadaga, Lee Shockley, Angela Keniston, *et al.*, *Hospitalist-led Medicine Emergency Department Team: Associations with Throughput, Timeliness of Patient Care, and Satisfaction*, 7 J. Hosp. Med. 562 (2012) (finding hospitalist collaboration with emergency department resulted in improved patient flow, more timely care to patients, and increased satisfaction with care).

[20] *See, e.g.*, American College of Physicians, *Primary Care-Hospital Care Team—Model Care Coordination Agreement*, https://hvc.acponline.org/primary-care-hospitalist-model-care-

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transfer of required patient clinical and other information at admission, during hospitalization and at discharge.[21] The hospitalist also establishes a means of contacting the outpatient provider during routine and urgent situations.[22] Additionally, the hospitalist keeps the primary care provider informed of major clinical developments and will involve the primary care provider "in significant patient care decisions that significantly impact care beyond the hospitalization . . . ."[23]

Given the hospitalist collaboration with outpatient physicians, there is no medical need for an outpatient provider to obtain admitting privileges. Even where a patient has a longstanding history with an outpatient provider, hospitalists are able to obtain pertinent medical records and information and administer high-quality inpatient care. This is particularly true in Texas, where the law requires ambulatory surgical centers to have transfer agreements with a hospital.[24]

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coordination-agreement.pdf (specifying that the hospital care team agrees to "Establish a standard communication protocol with PCP that ensures secure, timely, and reliable transfer of information.").

[21] *Id.* (clarifying that the protocol should address "transfer of required patient clinical and other information at admission, during hospitalization and at discharge").

[22] *Id.*

[23] *Id.*

[24] 25 Tex. Admin. Code §§ 135.4(c)(11), 135.11(b)(19). A transfer agreement specifies how and when a patient should be

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For example, a pregnant woman choosing to deliver at a hospital employing ob-gyn hospitalists—sometimes known as laborists—will be treated by the ob-gyn hospitalist on duty when she goes into labor rather than her outpatient ob-gyn. The outpatient ob-gyn providing pre-natal care does not need to maintain admitting privileges. And, although the ob-gyn hospitalist did not provide prenatal care or have an established history with the patient, medical studies have found the ob-gyn hospitalist model has more patients deliver via low-risk vaginal birth and fewer high-risk cesarean section deliveries—likely because the ob-gyn hospitalist hospitals could offer 24-hour rapid access to an ob-gyn.[25]

Dividing obstetric care between inpatient and outpatient physicians benefits patients and physicians alike. For example, having ob-gyn hospitalists perform deliveries during a scheduled shift means a woman in labor is less likely to be treated by an overtired physician, and patients with outpatient pre-natal appointments are not disrupted by their physicians being called to the hospital. Having a consistent schedule improves physicians' quality of care. The American College of Obstetricians and Gynecologists ("ACOG"), which has endorsed the ob-gyn hospitalist model and cited

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sent to a hospital for emergency care and may require that certain documentation accompany the patient to the hospital.

[25] *See* Crystal Phend, *New OB Care Models Boost Birth Outcomes*, MedPage Today, Feb. 19, 2013, http://www.medpagetoday.com/MeetingCoverage/SMFM/37437.

its potential to improve patient care and health outcomes, has also noted that as more deliveries are handled by ob-gyn hospitalists, many outpatient ob-gyns will not provide the minimum number of hospital procedures needed to maintain admitting privileges.[26]

Prenatal obstetric care often entails substantial interaction between a patient and her outpatient physician over many months. Nonetheless, the ob-gyn hospitalist model demonstrates the ability of the hospitalist to provide the required high quality medical care without reliance on the outpatient provider.

In contrast to prenatal obstetric care, however, many types of outpatient procedures require and reflect little to no historical relationship between physician and patient beyond the discrete procedure. Some outpatient procedures, such as abortion, may entail a handful of meetings between patient and physician. Regardless whether there is a deep relationship between patient and outpatient physician or they have only just met, the hospitalist is able to ensure continuity of care and high quality care. Thus, whatever benefit might theoretically be ascribed to potential continuity of care based on a

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[26] *See The Obstetric-Gynecologic Hospitalist*, ACOG Committee Opinion, June 2010 (reaffirmed 2012), http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Patient-Safety-and-Quality-Improvement/The-Obstetric-Gynecologic-Hospitalist; *Ob Gyns Support Growing Trend of Hospitalists*, ACOG, June 21, 2010, http://www.acog.org/About-ACOG/News-Room/News-Releases/2010/Ob-Gyns-Support-Growing-Trend-of-Hospitalists

longstanding historic relationship between the outpatient provider and the patient, is absent in connection with abortions and similar procedures.

## III. Admitting Privileges for Physicians Who Specialize in Outpatient Procedures with Low Incidence of Post-Procedure Complications, Such As Abortion, Serve No Medical Function

The legislative history of H.B. 2 explains the admitting privileges requirement thusly: "[w]omen who choose to have an abortion should receive the same standard of care any other individual in Texas receives, regardless of the surgical procedure performed . . . ."[27] Yet the Texas legislature did not indicate what medical benefit they perceived in H.B. 2's admitting privileges requirement. It may well be that the legislature simply assumed a significance for admitting privileges that does not exist in practice.

For example, a lay person, hearing the term "admitting privileges" might simply assume that "admitting privileges" provides easier access to hospital care in emergencies than would be available to the patients of an abortion provider that did not possess admitting privileges.

Similarly, the term "admitting privileges" might be taken as indicating that the possessor of those privileges enjoys some special level of competence.

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[27] Laubenberg, et al., Senate Research Center, H.B. 2, Bill Analysis, 83S20017 JSC-F (2013).

Or third, it might simply be assumed that an abortion provider with admitting privileges might be able to provide a better level of care than would otherwise be available to a woman who has had an abortion.

None of these assumptions are valid.

### A. Admitting Privileges Are Not Required In Order To Have A Patient In Need Admitted To A Hospital.

As to the notion that admitting privileges will facilitate admission to a hospital by a woman in need, this is plainly not the case. The Seventh Circuit's decision in *Planned Parenthood of Wisconsin, Inc. v. Schimel* addressed this issue in straightforward terms:

> A woman who experiences complications from an abortion (either while still at the clinic where the abortion was performed or at home afterward) will go to the nearest hospital, which will treat her regardless of whether her abortion doctor has admitting privileges.[28]

Assuming a woman suffering from complications presents at a hospital emergency room, in all likelihood she will be cared for by a physician without admitting privileges because most emergency room physicians do not have them.[29] If

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[28] *Planned Parenthood of Wisconsin, Inc. v. Schimel*, -- F.3d --, No. 15-1736, 2015 WL 7424017 at *4 (7th Cir. Nov. 23, 2015).

[29] American College of Emergency Physicians, Clinical & Practice Management, Writing Admission and Transition Orders ("Emergency physicians generally do not have admitting privileges and do not provide continuing inpatient

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the woman must be admitted to the hospital, a hospitalist, working in concert with the emergency department, can admit her and ensure she receives appropriate care.[30] And an "abortion doctor [does not] need admitting privileges at a hospital in order to call an ambulance to take his patient to the nearest hospital, or to communicate with the treating doctor at the hospital . . . ."[31]

### B. An Admitting Privileges Requirement For Abortion Providers Does Not Enhance Either The Continuity or Quality Of Care.

As explained above, under current medical practice—and especially the hospitalist approach to inpatient care—the quality and continuity of care does not depend on whether an outpatient physician has admitting privileges. This is particularly true in the case of abortion providers.

Abortion providers do not need to admit patients to hospitals or perform clinical procedures in a hospital setting for their abortion practice. Rather, current medical practice is for abortion providers to "have a plan to provide prompt emergency services if a complication occurs" and to have "a mechanism for transferring patients who

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care."), https://www.acep.org/Clinical---Practice-Management/Writing-Admission-and-Transition-Orders/ (last visited Dec. 11, 2015).

[30] *See supra* n.19.

[31] *Planned Parenthood of Wisconsin, Inc. v. Schimel*, -- F.3d --, No. 15-1736, 2015 WL 7424017 at *5 (7th Cir. Nov. 23, 2015).

require emergency treatment."[32] Thus, the presence or absence of admitting privileges is wholly irrelevant to an abortion provider's clinical competence and the quality of care a woman would receive in the event of post-abortion hospitalization. Under the hospitalist model, hospitalists ensure high-quality patient care regardless of whether the patient's outpatient physician has admitting privileges, practice privileges, or no privileges whatsoever.

Texas has not enacted admitting privileges requirements for any other outpatient procedures or providers. The absence of any similar admitting privileges requirements for comparable outpatient procedures is itself a strong indication that there is no medical rational for H.B. 2's admitting privileges requirement.

### C. Admitting Privileges Are Not A Barometer of Clinical Competence

A hospital's decision whether to grant a provider admitting privileges is discretionary, and a failure to grant such privileges does not signal a lack of

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[32] ACOG, *Guidelines for Women's Health Care: A Resource Manual* 720 (4th ed. 2014) ("Clinicians who perform abortions ... should have a plan to provide prompt emergency services if a complication occurs and should establish a mechanism for transferring patients who require emergency treatment."); *see also* Am. Ass'n for Accreditation of Ambulatory Surgery Facilities, Inc., *Regular Standards and Checklist for Accreditation of Ambulatory Surgery Facilities* 49 (2014); Nat'l Abortion Fed'n, *2013 Clinical Policy Guidelines* 55 (2013).

competency.[33] Clinical competence is but one aspect of hospitals' credentialing criteria. Indeed, a provider's ability to obtain admitting privileges may bear no relationship to technical proficiency. The Fifth Circuit itself acknowledged that providers may be unable to obtain admitting privileges for reasons other than clinical competency.[34]

For example, religiously affiliated hospitals may require providers to comply with ethical religious directives in order to obtain admitting privileges.[35] Hospitals also may require providers to admit a

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[33] Wendy Crimp, Sally J. Pelletier, Vicki L. Searcy, and Mark Smith, *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-based Privileges 4th Ed.* 4 (2007) (explaining that although credentialing should aim at ensuring quality of care, hospitals have other incentives including protecting the institutional reputation, minimizing legal risk, and enhancing overall marketability).

[34] Pet. App. 70a-71a ("With respect to the admitting privileges requirement, Whole Woman's Health presented considerable evidence that Plaintiff Dr. Lynn and three unidentified physicians working at the McAllen facility were unable to obtain admitting privileges for reasons other than their competence.")

[35] *See, e.g.*, MedStar Georgetown University Hospital, Credentialing, http://www.medstargeorgetown.org/for-physicians/credentialing/#q={} (last visited Dec. 8, 2015) ("Per the Bylaws, a Practitioner (MD, NP, Psychologist, DPM, DDS, DMD, LSCW) who wishes to apply for privileges and become a member of the Staff at MedStar Georgetown University Hospital shall establish that he or she meets the following qualifications . [a]greement of the Practitioner to comply with the Ethical Religious Directives in regard to matters involving pastoral care, patient care, care for the beginning of life, and care for the dying on the Hospital clinical campus.").

minimum number of patients annually or provide a minimum number of services in the hospital setting to qualify for admitting privileges.[36]

The Joint Commission, an independent not-for-profit organization that accredits and certifies health care organizations throughout the United States, recommends that hospitals evaluate the quality of services provided by its physicians with admitting privileges on a continuing basis.[37] But, as discussed earlier, many outpatient physicians—especially abortion providers—do not admit a sufficient number of patients or perform enough procedures in the hospital setting to enable review and oversight by standard means. This provides a further disincentive to granting privileges to "low-volume" outpatient physicians such as abortion providers.[38]

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[36] Wendy Crimp, Sally J. Pelletier, Vicki L. Searcy, and Mark Smith, *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-based Privileges 4th Ed.* 126 (2007) (explaining that a hospital's credentialing committee "must determine the minimum number of procedures (or admissions or cognitive privileges) that a practitioner must perform to qualify for the privileges he or she requests."); *see also* Anne Roberts, *The Essential Guide to Medical Staff Reappointment: Tools to Create and Maintain an Ongoing, Criteria-Based Process, 2d Ed.* 39 (2008) (noting that most organizations set volume requirements as part of the re-privileging process).

[37] The Joint Commission, Standards FAQ Details, Medical Staff (CAMH/Hospitals) Jan. 31, 2013, http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=467&StandardsFAQChapterId=74 (last visited Dec. 11, 2015).

[38] *See* Hugh P. Greeley, *A Practical Guide to Assessing the Competency of Low-volume Providers*, 60 (2004) (discussing the

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This underscores the fact that the granting of admitting privileges is often a business decision, as much, if not more than it is a medical decision. In short, the criteria that hospitals use when deciding whether to grant providers admitting privileges are far from uniform, are a poor proxy for qualitative judgments about provider competence, and are inappropriate bases for protecting women's health.

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burden on hospitals reviewing requests for privileges from low- or no-volume providers); [38] Mark A. Smith and Sally Pelletier, *Assessing the Competency of Low-Volume Practitioners: Tools and Strategies for OPPE and FPPE Compliance, 2d Ed.* 79 (2009) (Recommending that low-volume physicians who are not clinically active at hospitals or hospital-owned ambulatory clinics not be given admitting privileges because "[t]hese practitioners put a strain on your organization's credentialing resources, use a great deal of the [medical staff services department]'s energy and time, and take up space on the credentialing committee's or [medical executive committee]'s agenda that should be devoted to more [economically] worthwhile activities.").

## CONCLUSION

For the foregoing reasons, amici urge the Court to recognize that Texas H.B. 2's admitting privileges requirement has no medical basis.

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